

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

46473 358  
Reg. Dist. No.

Evidence for addition of items 17 & 18 is shown on File No. G95, June 20, 1945.  
**CERTIFICATE OF DEATH**

## 1. PLACE OF DEATH:

County Worcester Co.  
City or town 3 1/2 miles E. of Worcester, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? minutes  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Wisconsin County Eau Claire  
City or town 724 Lee Street  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 724 Lee Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Robert Harold Anderson

## 3. (b) Social Security Number

4. Sex M 5. Color or race W. 6.(a) Single, married, widowed, or divorced M.

6.(b) Name of husband or wife Virginia Mae Anderson  
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 - 1918

8. AGE: Year 26 Months 8 Days 18 If less than one day hrs. min.

9. Birthplace Eau Claire, Wisconsin  
(Town, county, and state)

10. Usual occupation Rural Carpenter

11. Industry or business U.S. Navy

12. Name Don't know

13. Birthplace Don't know

14. Maiden name Don't know

15. Birthplace Don't know

16. Informant Dr. R. G. Perry

Address 714 N. 4th St. Chippewa Falls

17. Burial Date thereof June 10, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Unknown

Location Eau Claire, Wisconsin

18. Funeral director E. B. Stokes

Address Eau Claire, Wisconsin

19. June 5 1945 Anne E. White  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 5th 1945 at 11:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from after death 1945 to 1945  
and that I last saw him before he had died on June 5th 1945

Immediate cause of death Accidental Trauma

Due to Crushing

Due to Fall in heavy plane

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/5/45

Where did injury occur? Near Jackson, Wisconsin (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Human Industries

Means of injury Fall in plane Injured at work? yes

Signature N. E. Astorius M.D. or other MD

Address Pescadore, Md. Date signed 6/5/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 15 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

## CERTIFICATE OF DEATH

Reg. Dist. No. 06474 355

## 1. PLACE OF DEATH:

County WorcesterCity or town Shawell  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Shawell  
(If outside city or town limits, write RURAL and give nearest town)Street No. no number  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Emery Baker

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Monie Baker7. Birth date of deceased (mo., day, yr.) July 12, 18768. AGE: Years 68 Months 11 Days 21 (If less than one day) hrs. min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Former11. Industry or business Former12. Name Josiah J. Baker13. Birthplace Md.14. Maiden name Mary A. Williams15. Birthplace Md.16. Informant Mrs. Emery BakerAddress Shawell17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof June 3, 1945

(month) (day) (year)

Cemetery or crematory WorshipLocation Berlin, Md.18. Funeral director W. Pasha WatsonAddress Selbyville, Del.19. 6-5- 45 Oklen F. Hayward

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1945 at 7 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15, 1943 to June 3, 1945and that I last saw him alive on June 2, 1945Immediate cause of death Coronary occlusion

DURATION

Due to myocarditis, arteriosclerosis 2x4 yrsDue to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank P. Lewis M.D. M. D. or otherAddress Willards, Md. Date signed 6-3-45

RECEIVED  
JUN 7 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 354

## 1. PLACE OF DEATH:

County WorcesterCity or town Stockton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Stockton  
(If outside city or town limits, write RURAL and give nearest town)Street No. ✓  
(If rural, give LOCATION)2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

James Edward Barnes

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married8.(b) Name of husband or wife Lizzie Barnes6.(c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) April 23-18738. AGE: Years 72 Months 1 Days 18 If less than one day hrs. min.9. Birthplace Kleg Grange, Worcester, Md.  
(Town, county, and state)10. Usual occupation Salesman

11. Industry or business

12. Name Elijah Barnes13. Birthplace md14. Maiden name Grace Hudson15. Birthplace md16. Informant Lizzie BarnesAddress Stockton, Md.17. Burial Date thereof June 13, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory PresbyterianLocation Stockton, Md.18. Funeral director Margarette H. WatsonAddress Pocomoke City, Md.19. June 12 1945 Mary M. Taylor  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 3:00 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/10/45 1945, to 6/11/45 1945, and that I last saw him alive on 6/11/45 1945Immediate cause of death Apoplexy

DURATION

1 dayDue to Arteriosclerosis1 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Paul Cohen M.D. M. D. or otherAddress Snow Hill Date signed 6/12/45

RECEIVED  
JUN 29 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 06476  
 Reg. Dist. No. 355

## 1. PLACE OF DEATH:

 County..... Worcester  
 City or town..... Rural - Ocean City, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 mo.

Hospital, institution, or street address where death occurred:

West Ocean City Road - R.F.D. 2

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Worcester

City or town..... Rural - Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No..... West Ocean City

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Gertrude May Clark

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Female White -

6. (b) Name of husband or wife.....

7. Birth date of..... 8. (c) If alive, give age..... years

deceased (mo., day, yr.) May 24, 1945

8. AGE: Years..... Months..... Days..... It less than one day.....

..... hrs. .... min.

9. Birthplace..... Ocean City R.F.D. 2\* Wor. Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... William J. Clark

13. Birthplace..... Ocean City Md. R.F.D.

14. Maiden name..... Jennie E. Hudson

15. Birthplace..... Ocean City Md. R.F.D.

16. Informant..... William J. Clark

Address..... Ocean City R.F.D. 2 #

17. Burial..... Date thereof..... June 25 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Evergreen Cem.

Location..... Berlin Md.

18. Funeral director..... Anna G. Burbyce

Address..... Berlin Md.

19. 6-25 45 Helen F. Hayward

(Date rec'd by registrar) 19..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 24, 1945, at 6:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 24, 1945, to June 24, 1945,

and that I last saw him alive on June 23, 1945.

Immediate cause of death.....

Subar Chokionoma

DURATION..... 3 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

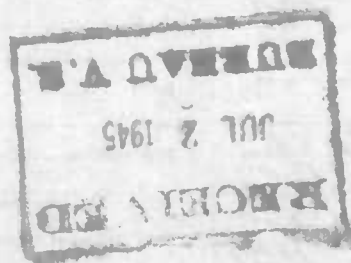
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... M. D. or other

Address..... Berlin Md. Date signed 6-24-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

## CERTIFICATE OF DEATH

 46477  
 Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County Worcester  
 City or town Rural - Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 yrs.  
 Hospital, institution, or street address where death occurred R.F.D.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Worcester  
 City or town Rural - Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.F.D.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Nelson Collic

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colo. Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Unknown

8. AGE: Years Months Days If less than one day

about 92

9. Birthplace

Worcester, Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER MOTHER

12. Name Wm. Isma Collic

13. Birthplace

Md.

14. Maiden name

Unknown

15. Birthplace

Md.

16. Informant

Address

Margie Purnell  
Berlin, Md. R.F.D.

17.

(Burial, cremation, or removal, Which?)

Date thereof June 27 1945  
(month) (day) (year)

Cemetery or crematory

St. Pauls Cem.

Location

Berlin, Md.

18. Funeral director

Address

Anna D. Burkay  
Berlin, Md.

19.

(Date rec'd by registrar)

6-27-45 Helen F. Hayward

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-45 19 45 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-1-45 19 45 to 6-25 19 45  
 and that I last saw him alive on 6-23 19 45

Immediate cause of death

chronic myocarditis  
chronic HT Hypertens

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Clifford E. Schett  
Berlin Md M. D. or other  
 Address Date signed 6-26-45

RECEIVED  
JUL 2 1945  
BUREAU A.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH: County Worcester  
 City or town Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 31 years  
 Hospital, institution, or street address where death occurred: —  
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. —  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war —

3. (a) FULL NAME Lillie Anne Colona 3. (b) Social Security Number —

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Harry W. Colona

7. Birth date of deceased (mo., day, yr.) August 13-1868 6. (c) If alive, give age — years

8. AGE: Years 76 Months 10 Days 12 It less than one day — hrs. — min.

9. Birthplace Chingotique Coaruro, Virginia  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

12. Name William P. Birch

13. Birthplace Unknown

14. Maiden name Birch C. Walker

15. Birthplace Unknown

16. Informant Mr. Harry Ellis

Address Pocomoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 28 1945  
 (month) (day) (year)

Cemetery or crematory Salem M.E. Cemetery

Location Pocomoke, Md.

18. Funeral director Margarette H. H. H.

Address Pocomoke City, Md.

19. July 2 1945 Anne E. Oute  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1945 to June 25 1945 and that I last saw him alive on June 23 1945

Immediate cause of death Senile dementia

Due to Arteriosclerosis

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE N. E. Santorini M. D. or other —

Address Pocomoke City, Md. Date signed 6/28/45

RECEIVED  
JUL 5 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH: Worcester  
County.....  
City or town..... Berlin, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 years  
Hospital, institution, or street address where death occurred:  
S. Main Street  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md. County..... Worcester  
City or town..... Berlin, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... S. Main St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Charlotte Elizabeth Furbush

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Edward S. Furbush

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1861

8. AGE: Years 84 Months 5 Days 13 If less than one day..... hrs. .... min.

9. Birthplace Berlin, Worcester, Md.  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business -

12. Name Isaac Tarr

13. Birthplace Md.

14. Maiden name Charlotte Richards

15. Birthplace Md.

16. Informant Olive Richardson

Address Berlin, Md.

17. Burial Date thereof June 19, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Buckingham Cem.

Location Berlin, Md.

18. Funeral director Anna G. Burlyge

Address Berlin, Md.

19. 6-19-45 Helen L. Hayward

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1945 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... M. D. or other

Date signed.....

CERTIFICATE OF DEATH

LOCAL BOARD OF HEALTH

MEDICAL CERTIFICATION

RECEIVED  
JUN 25 1945  
BUREAU U.S.

Mr. Thompson

Mr. Thompson

Mr. Thompson

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County WorcesterCity or town Rural Pocomoke  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Rural Pocomoke Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Julia Ann Gossard

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

married

## 6.(b) Name of husband or wife

John E. Gossard

## 7. Birth date of deceased (mo., day, yr.)

Oct 2, 1865

## 6.(c) If alive, give age

80 years

## 8. AGE:

Years

Months

Days

If less than one day

79810

hrs.

min.

## 8. Birthplace:

Rocky Mt. Patrick Va.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

John P. Hancock

## 13. Birthplace

Va.

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

## 16. Informant

Jessie Gossard

## Address

Pocomoke Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

June 14, 1945  
(month) (day) (year)

## Cemetery or crematory

Salmon Mt. Cemetery

## Location

Pocomoke Md.

## 18. Funeral director

Margaret H. H. H. H.

## Address

Pocomoke Md.

## 19. June 14, 1945

(Date rec'd by registrar)

Anne E. White

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 12, 1945, at 5 AM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1943 to June 7, 1945and that I last saw him alive on June 7, 1945

## Immediate cause of death

General ataxia

## Due to

Chronic Endocarditis

## Due to

Hyperemia

## Other conditions

Hyperemia

(Include pregnancy within 8 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

W. E. Gossard  
Address Pocomoke City, Md. Date signed 6/14/45

M. D. or other

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JUN 16 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

## CERTIFICATE OF DEATH

Reg. Dist. No. 353

## 1. PLACE OF DEATH:

County WorcesterCity or town Seebysville Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WorcesterCity or town Seebysville, Del.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Rachel Hall

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife John Hall6.(c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) march, 8, 18748. AGE: Years 71 Months 3 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name James Bunting13. Birthplace Md.14. Maiden name Nancy Layton15. Birthplace Md.16. Informant John HallAddress Seebysville, Del.17. Burial Date thereof June 26, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ebenezer ChurchyardLocation near Seebysville, Del.19. Funeral director Margarette W. WatsonAddress Pocomoke City, Md.19. June 25 19 45 Mrs. Roy Buggy  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 23 19 45 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 45 to June 23 19 45  
and that I last saw him alive on 6-26 19 45Immediate cause of death Carcinoma of stomach

DURATION

1 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hypertension, Cardiac VaseRenal Disease

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert S. Long M. D. or otherAddress Frankford Del Date signed 6-25-45

RECEIVED  
JUN 26 1945  
BUREAU V.R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

16482

Reg. Dist. No. 350

### 1. PLACE OF DEATH:

County Worcester  
City or town RURAL, Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 50 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town RURAL, Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Rt. # 2  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Caroline Holland

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife Handy Holland  
7. Birth date of deceased (mo., day, yr.) Month & Day Unknown-1883 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 62 Months - Days - If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace RURAL, Pocomoke-Worcester-Md.  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name John Dickerson

13. Birthplace Worcester County, Md.

14. Maiden name Sallie Christian

15. Birthplace Worcester County, Md.

16. Informant William Dickerson

Address 4 Sixth St., Pocomoke City, Md.

17. Burial Date thereof June 15, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Halls Hill Cemetery

Location Pocomoke City, Maryland

18. Funeral director H. Harvey Bradshaw

Address Pocomoke City, Maryland

19. June 15, 1945 Anne E. White  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH June 12 1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him alive on June 3rd 1945

Immediate cause of death Ischemic heart disease

Due to Arteriosclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE V. E. Williams M.D. or other \_\_\_\_\_

Address Pocomoke City, Md. Date signed 6/13/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 18 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 06483 355

## 1. PLACE OF DEATH:

County... Worcester  
 City or town... Rural - Berlin, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long to hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md. County... Worcester  
 City or town... Rural - Berlin, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Berlin R.F.D.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Margaret Ann McCabe

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Joshua G. McCabe

7. Birth date of deceased (mo., day, yr.) June 17, 1865

8. AGE: 79 Years 11 Months 23 Days It less than one day hrs. min.

9. Birthplace Berlin, Worcester, Md.  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name John Timmons  
 13. Birthplace Md.

14. Maiden name Martha Timmons  
 15. Birthplace Md.

16. Informant Garland McCabe  
 Address Berlin, Md.

17. Burial Date thereof June 12, 1945  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Evergreen Cem.  
 Location Berlin, Md.

18. Funeral director Anna A. Burlingame  
 Address Berlin, Md.

19. 6-12-45 Helen F. Hayward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Chr. Nephritis

Due to

Due to

Other condition

Chr. Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R. Law

M. D. or other

Address Berlin, Md. Date signed 6/11/45

CERTIFICATE OF DEATH

RECEIVED  
JUN 15 1945  
BUREAU V.P.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County Worcester  
 City or town Rural-Berlin R.F.D. 2#  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 mo, 20 days  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Rural-Berlin R.F.D. 2#  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.F.D. 2#  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Peggy Ann Morris

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored -

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1945

8. AGE: Years Months Days If less than one day

9. Birthplace Whaleyville, Worcester, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Harry Morris13. Birthplace Berlin, Md.MOTHER 14. Maiden name Anna Quillen15. Birthplace Berlin, Md.16. Informant Harry MorrisAddress Berlin R.F.D. 2#17. Burial Date thereof June 16, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Germanatown CemeteryLocation Berlin, Md.18. Funeral director Anna A. BurlageAddress Berlin, Md.19. 6-16 45 Helen E. Hayward  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945 at 8:30 AM21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1st 1945 to June 16 1945and that I last saw him alive on June 16 1945Immediate cause of death Acute Bronchial PneumoniaDURATION 7 daysDue to Upper respiratory disease 1 wk.

Due to

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. S. Fucile M.D.

M. D. or other

Address Berlin, Md. Date signed 6/16/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JUN 19 1945  
BUREAU V.M.

RECEIVED JUN 19 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 06485 955

1. PLACE OF DEATH:  
County..... Worcester  
City or town..... Rural - Berlin  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 40 yrs.  
Hospital, institution, or street address where death occurred:  
R.F.D. 2#  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Worcester  
City or town..... Rural Berlin  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... R.F.D. 2#  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Sarah Margaret Quillin 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife John L. Quillin

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1866 6. (c) If alive, give age..... years

8. AGE: Years 79 Months 9 Days 16 If less than one day..... hrs. .... min.

9. Birthplace Berlin, Worcester, Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas B. Birch

13. Birthplace Ocean City, Md.

14. Maiden name Martha Bowen

15. Birthplace Berlin, Md.

16. Informant Mrs. Ned. Gray

Address Berlin Md. R.F.D. 2#

17. Burial Date thereof June 26, 1945  
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Evergreen Cem.

Location Berlin Md.

18. Funeral director Anna D. Bunge

Address Berlin Md.

19. 6-26-45 19. 45 Helen F. Hayward  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1945 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1945 to June 24 1945 and that I last saw her alive on June 24 1945

Immediate cause of death Carcinoma of Cervix DURATION 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. H. H. M.D.

Address Berlin, Md. M. D. or other

Date signed 6-24-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JUL 2 1945  
BUREAU A.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH: Worcester  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, institution, or street address where death occurred:.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland..... County..... Worcester  
City or town..... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Ann's Luntton

## 3. (b) Social Security Number

no

4. Sex..... Female  
5. Color or race..... Col  
6.(a) Single, married, widowed, or divorced..... married  
6.(b) Name of husband or wife..... Spencer Luntton  
7. Birth date of deceased (mo., day, yr.)..... about 1880  
6.(c) If alive, give age..... years

8. AGE: Years..... about 65  
Months.....  
Days.....  
If less than one day..... hrs. .... min.

9. Birthplace..... Salisbury Md  
(Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business..... Same as above

12. Name..... Ann's Luntton

13. Birthplace..... Salisbury Md

14. Maiden name..... Charlotte Washell

15. Birthplace..... Ralham, Alkings

16. Informant..... Spencer Luntton

Address..... Salisbury Md

17. Burial (Burial, cremation, or removal. Which?)..... Date thereof.....  
(month) (day) (year)

Cemetery or crematory.....

Location..... Salisbury Md

18. Funeral director..... James H. Stewart

Address..... Salisbury Md

19. 6-27, 45 Helen F. Hayward  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 27, 1945, at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Duration..... hr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... Date signed.....

Signature..... M. D. or other

Address..... Date signed.....

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES OF AMERICA

RECEIVED  
JUN 2 1945  
DEPARTMENT OF JUSTICE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

487

## 1. PLACE OF DEATH

County Washington Registration Dist. No. 354  
 Village or City Stoughton No.      St.      Ward       
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred      yrs.      mos.      ds. How long in U. S. if of foreign birth?      yrs.      mos.      ds.

## 2. FULL NAME

(a) Residence: No.      St.      Ward.       
 (Usual place of abode)  
 If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED ( <i>write the word</i> ) <u>Single</u>
5e. If married, widowed, or divorced HUSBAND of <u>    </u> (or) WIFE of <u>    </u>		
6. DATE OF BIRTH (month, day, and year) <u>8/8/90</u>		
7. AGE <u>55</u>	Years	Months Days
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Farm Lab.</u>		11. Total time (years) spent in this occupation <u>    </u>
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>    </u>		10. Date deceased last worked at this occupation (month and year) <u>    </u>

FATHER	12. BIRTHPLACE (city or town) (State or country) <u>    </u>
	13. NAME <u>George W. Rowley</u>
MOTHER	14. BIRTHPLACE (city or town) (State or country) <u>    </u>
	15. MAIDEN NAME <u>    </u>
	16. BIRTHPLACE (city or town) (State or country) <u>    </u>
	17. INFORMANT <u>Ernest B. Quatt</u> (Address) <u>Stoughton, Md.</u>
18. BURIAL, CREMATION, OR REMOVAL Place <u>Home</u> Cemetery <u>Stoughton</u> Date <u>Jan. 13</u> , 19 <u>47</u>	
19. UNDERTAKER <u>Ernest B. Quatt</u> (Address) <u>Stoughton, Md.</u>	
20. FILED <u>Jan. 12</u> , 19 <u>47</u> <u>Mary M. Taylor</u> Registrar.	

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH <u>Jan 11</u> , 19 <u>45</u> (Month) (Day) (Year)
22. I HEREBY CERTIFY, That I attended deceased from <u>Jan 3</u> , 19 <u>45</u> to <u>Jan 11</u> , 19 <u>45</u> . I last saw <u>    </u> elive on <u>Jan 3</u> , 19 <u>45</u> ; death is said to have occurred on the date stated above, at <u>5 P.</u> m. The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows: <u>Chronic Myocarditis</u> Date of onset <u>    </u>
Other Contributory Causes of Importance: <u>    </u>
Name of operation <u>    </u> Date of <u>    </u> What test confirmed diagnosis? <u>    </u> Was there an autopsy? <u>    </u>
23. If death was due to external causes (VIOLENCE) fill in also the following: Accident, suicide, or homicide? <u>    </u> Date of injury <u>    </u> , 19 <u>    </u> Where did injury occur? <u>    </u> (Specify city or town, county and State) Specify whether injury occurred In INDUSTRY, In HOME, or In PUBLIC PLACE.
Manner of injury <u>    </u> Nature of injury <u>    </u>
24. Was disease or injury in any way related to occupation of deceased? If so, specify <u>    </u> (Signed) <u>    </u> M. D. (Address) <u>    </u>

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

06488

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County WorcesterCity or town Ocean City  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

8 No. 11<sup>th</sup> St.How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4856 Cherry Chase Blvd.  
(If rural, give LOCATION)2.(a) If veteran, name war — ✓

## 3. (a) FULL NAME

Cora Dodson Sasser

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Henry H. Sasser6. (c) If alive, give age 53 years

## 7. Birth date of

deceased (mo., day, yr.)

Feb. 15, 1892

## 8. AGE:

Years

53

Months

4

Days

12

If less than one day

— hrs. — min.

## 9. Birthplace

St. Michaels, Md.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

## 12. Name

E. Ney Dodson

## 13. Birthplace

St. Michaels, Md.

MOTHER

## 14. Maiden name

Alvina Hoffmann

## 15. Birthplace

Trappe, Md.

## 16. Informant

Widow - Henry H. Sasser

## Address

4856 Cherry Chase Blvd. Wash. DC

## 17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

June 24, 1945  
(month) (day) (year)

## Cemetery or crematory

St. Thomas Cem.

## Location

Ordom, Md.

## 18. Funeral director

Anna G. Burtage

## Address

Berlin, Md.

## 19. 6-27

(Date rec'd by registrar)

19 45

Helen E. Hayward

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945, at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 27, 1945, to June 27, 1945, and that I last saw him alive on June 27, 1945Immediate cause of death Cornary Occlusion

## DURATION

less than 1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

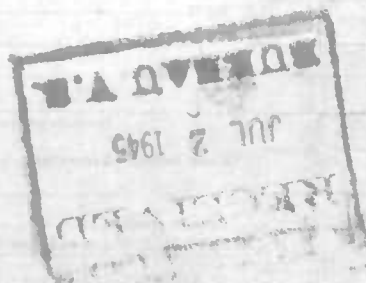
Kenneth L. Hayes, M.D.  
M.D. or other

Address

Ocean City, Md.

Date signed

June 27, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

FILM NO. G 96 JUN 29 1945

## CERTIFICATE OF DEATH

06489  
★ Reg. Dist. No. 351

### 1. PLACE OF DEATH:

County Worcester  
City or town Royal, Newark, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Joseph Henry Spence

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Amanda Spence

7. Birth date of

deceased (mo., day, yr.)

July 15, 1852

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Newark, Worcester, Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farming

12. Name

W. Spence

13. Birthplace

Md.

14. Maiden name

Unknown

15. Birthplace

Md.

16. Informant

Bruce Spence

Address

Newark, R.F.D. 1

17. Burial

(Burial, cremation, or removal. Which?)

Date thereon

June 23, 1945

(month) (day) (year)

Cemetery or crematory

Cedar Chapel Cem.

Location

Newark, Md.

18. Funeral director

Anna A. Bynum

Address

Berlin, Md.

19. June 23, 1945

(Date rec'd by registrar)

L. E. Roy Smith

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Royal - Newark  
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. 1

(If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

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RECEIVED  
JUN 25 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1150

## CERTIFICATE OF DEATH

06490

Reg. Dist. No. 351

## 1. PLACE OF DEATH:

County WorcesterCity or town Snow Hill  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 73 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Snow Hill  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war. 70

## 3.(a) FULL NAME

Thomas T. Trader

## 3.(b) Social Security Number

None4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Ernie B. Trader6.(c) If alive, give age 79 years7. Birth date of deceased (mo., day, yr.) Nov. 27 - 18618. AGE: Years 73 Months 6 Days 29 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Snow Hill, Worcester, MD  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farmer12. Name Samuel Trader13. Birthplace Maryland14. Maiden name Unknown

15. Birthplace \_\_\_\_\_

16. Informant Mr. Lloyd T. TraderAddress Snow Hill, MD17. (Burial, cremation, or removal, which?) Cremation Date thereof June 27, 1945  
(month) (day) (year)Cemetery or crematorium BethesdaLocation Snow Hill, MD18. Funeral director Heard & SonsAddress Snow Hill, MD19. 69271 19 45 LeRoy Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 45 at 4:15 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18 19 45 to June 26 19 45and that I last saw him alive on June 25 19 45Immediate cause of death Simple ScurvationDue to Complete pharyngealDue to obstructionOther conditions + senility

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert L. La Mar, MD  
Address Snow Hill M. D. or other \_\_\_\_\_Date signed 6/27/45

RECEIVED  
JUN 30 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County WorcesterCity or town Berlin, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo.

Hospital, institution, or street address where death occurred:

Vine StreetHow long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No. Vine Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Radcliff Whittington

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Francis Whittington7. Birth date of deceased (mo., day, yr.) Dec. 8, 18528. AGE: Years 92 Months 7 Days 8 If less than one day

hrs. min.

8. Birthplace Berlin RFD 3# Worcester, Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name John Whittington13. Birthplace Berlin, R.F.D. 3#14. Maiden name Millie Webb15. Birthplace Berlin R.F.D. 3#16. Informant Edna WhittingtonAddress Berlin, Md.17. Burial Date thereof 6-16-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Burbage CemeteryLocation Powellville Md.18. Funeral director Anna A. BurbageAddress Berlin, Md.19. 6-16 1945 Helen S. Hayward

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19— to 19—and that I last saw him alive on June 13 1945

Immediate cause of death

DURATION

Chr. nephritis

Due to

Due to

Other conditions Diabetes mellitus

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R. Faw M. D. or otherAddress Berlin Md. Date signed 6/15-45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECORDED  
JUN 21 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 06492 355

1. PLACE OF DEATH:  
 County Worcester  
 City or town near Snow Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town near Snow Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION) 70  
 2.(a) If veteran, name war

3. (a) FULL NAME Elsie G. Wilson

3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5 - 1929

8. AGE: Years 15 Months 6 Days 3 If less than one day hrs. min.

9. Birthplace Winfield Somerset, MD  
 (Town, county, and state)

10. Usual occupation School Girl

11. Industry or business

12. Name Isaac W. Wilson

13. Birthplace Maryland

14. Maiden name Bessie J. Griffith

15. Birthplace Maryland

16. Informant Mrs. Bessie J. Griffith

Address Snow Hill, MD Rural?

17. Burial Date thereof June 11/45  
 (Burial, cremation, or removal, Which) (month) (day) (year)

Cemetery or crematory Methodist Ministers

Location Winfield

18. Funeral director Flame & Summers

Address Snow Hill, MD

19. 6-11-45 Helen F. Hayward  
 (Date rec'd by registrar) registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 45 at 11:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 19 45 to June 8 19 45

and that I last saw him alive on June 8 19 45

Immediate cause of death Fracture skull DURATION at once

Due to Auto accident

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: June 8 '45  
 Accident, suicide, or homicide accident Date of June 8 '45

Where did injury occur near Worcester MD  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway No. 113

Means of injury Auto accident Injured at work?

23. SIGNATURE John L. Riley Dep. Med Exam  
 M. D. or other

Address Snow Hill MD Date signed 6/9/45

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

JUN 15 1945

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

## 1. PLACE OF DEATH:

County WicomicoCity or town Snow Hill  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

June 29/45

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

1hrs.min.

9. Birthplace

Snow Hill Wicomico MD

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. 6/30/45

(Date rec'd by registrar)

LeRoy Smith

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD

County

Wicomico

City or town

Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 301945

at

5 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 291945

to

June 301945

and that I last saw her alive on

June 291945

Immediate cause of death

Respiratory failure

DURATION

Due to

Premature Birth

Due to

1 day

Due to

1 day

Due to

1 day

Due to

1 day

Due to

1 day

Due to

1 day

Due to

1 day

Due to

1 day

Due to

1 day

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1 day

Due to

1 day

Due to

1 day

Due to

1 day

23. SIGNATURE

Robert L. LaMar

M. D. or other

Address

Snow Hill

Date signed

6/30/45

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED  
JUL 15 1945  
BUREAU V. S.